AUDIT REPORT

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
AND
DEPARTMENT OF HEALTH
SPECIAL REVIEW OF THE
HOME HEALTH CARE EXPENDITURES

From The Office Of State Auditor
Claire McCaskill

Report No. 99-74
September 9, 1999

Office Of The
State Auditor Of Missouri
Claire McCaskill

September 1999

FACT SHEET

The National State Auditor's Association is currently conducting a joint audit of home health care related issues. The Missouri State Auditor's Office is participating in this joint audit. The following findings were noted during our review of home health care issues at the Department of Health and expenditures for home health care services from the Medicaid Program administered by the Department of Social Services, Division of Medical Services.

The State Auditor recommended improvements be made to the Department of Health's home health agency inspection process. The state's Department of Health is responsible for licensing and inspecting all home health agencies. If deficiencies are noted during the inspections, follow-up procedures are performed to ensure that deficiencies are corrected. The auditor noted instances where deficiencies noted during a state inspection were supposedly corrected during the follow-up visit but some of the same deficiencies were again cited within four to ten months after the follow-up visit was performed.

The State Auditor's review also found that department records did not adequately document the procedures performed to determine that the deficiency was actually corrected. Instances were noted where the department concluded deficiencies had been corrected even though additional exceptions were noted during the follow-up visit. It appears the department's criteria for determining if a deficiency is corrected is flawed.

The State Auditor's review noted individual plans of care were not always signed by the physician, were signed by the physician but not within the time frames required by federal and state regulations, or were not dated by the physician. In addition, verbal orders from the physician were not always properly documented by the attending nurse or therapist. This documentation is necessary to ensure compliance with state and federal regulations and to ensure necessary and appropriate care is being provided. In a test of claims, the auditor noted approximately $66,000 in claims paid when the documentation was deficient.

Home health services provide medical treatment or supervision to individuals with acute illness, or an exacerbation of a chronic or long term illness, which can be therapeutically managed at home. These services include nursing services, home health aid services, physical therapy, occupational therapy, or speech pathology services provided by a home health agency based on a physician's written plan of care.

Home health agencies are licensed with and inspected by the state's Department of Health. The state pays for services to eligible recipients through the state's Medicaid Program. The Department of Social Services, Division of Medical Services, is responsible for ensuring claims are properly paid under this program. During the year ended June 30, 1998, the state processed home health care claims which totaled approximately $8.5 million.

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
AND
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SPECIAL REVIEW OF THE
HOME HEALTH CARE EXPENDITURES

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Missouri State Auditor

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and
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Department of Health
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Gary J. Stangler, Director
Department of Social Services
and
Gregory A. Vadner, Director
Division of Medical Services
Jefferson City, MO 65102

We have conducted a special review of home health care expenditures of the Medicaid Program administered by the Department of Social Services, Division of Medical Services, and the Department of Health. The objectives of this review were to:

1. Determine whether the services billed for clients by the providers are properly authorized, approved, allowable, and provided.

2. Determine whether providers are meeting state licensure/certification requirements and if those requirements are sufficient.

3. Determine the adequacy of the complaints/monitoring process for service providers.

4. Determine whether procedures are in place to ensure that quality care is provided to clients.

Our review was made in accordance with applicable generally accepted government auditing standards and included such procedures as we considered necessary in the circumstances. In this regard, we interviewed applicable personnel and inspected relevant records and reports of the Department of Health (DOH) and the Department of Social Services - Division of Medical Services (DMS), and various home health care agencies providing such services.

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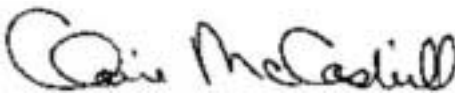
As part of our review, we considered the DOH's and DMS's management controls to the extent we determined necessary to evaluate the specific matters described above and not to provide assurance on those controls. With respect to management controls, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation and we assessed the control risk. In order to assess control risk, we performed tests of controls to obtain evidence regarding the effectiveness of the design and operation of certain policies and procedures.

Our review was limited to the specific matters described above and was based on selective tests and procedures considered appropriate in the circumstances. Had we performed additional procedures, other information might have come to our attention that would have been included in this report.

The accompanying Background Information is presented for information purposes. This information was obtained from the Department of Health and the Department of Social Services, Division of Medical Services, and was not subject to the procedures applied in the review of home health care expenditures.

The accompanying Management Advisory Report presents our findings and recommendations arising from our review of home health care expenditures.



Claire McCaskill
State Auditor

April 30, 1999 (fieldwork completion date)

BACKGROUND INFORMATION

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
AND
DEPARTMENT OF HEALTH
SPECIAL REVIEW OF HOME
HEALTH CARE EXPENDITURES

BACKGROUND INFORMATION

Home health services provide medical treatment or supervision to individuals with an acute illness, or an exacerbation of a chronic or long term illness, which can be therapeutically managed at home. These services include nursing services, home health aide services, physical therapy, occupational therapy, or speech pathology services provided by a home health agency on the physician's orders as part of a written plan of care that the physician reviews at least every 60 days. To participate in the state's Medicaid Program, the home health agency must be currently licensed with the Department of Health, be Medicare certified, and have a current Missouri Medicaid provider agreement with the Department of Social Services, Division of Medical Services (DMS). As of June 1998, approximately 280 home health agencies were licensed to provide services to Medicaid eligible recipients.

The Department of Health (DOH) is responsible for ensuring that home health agencies are properly licensed in accordance with federal and state guidelines. Sections 197.440 through 197.445, RSMo 1994, require all home health agencies to be licensed and registered with the department as evidenced by a survey inspection by the department. Survey inspections for agencies in operation for less than 36 consecutive months are required to be inspected at least every 12 months. Agencies that have been in operation for over 36 consecutive months have inspections performed only every 36 months if these agencies meet certain criteria which exempts them from annual inspections.

The DMS is responsible for ensuring all claims for home health care services are reimbursed in accordance with federal and state requirements.

During the fiscal year ended June 30, 1998, the DMS processed 40,959 home health care claims which totaled approximately $8.5 million. In total for the Medicaid Program in fiscal year 1998, approximately 22.7 million claims were paid with expenditures of the program totaling approximately $2.5 billion.

The National State Auditor's Association is currently conducting a joint audit of home health care related issues. The Missouri State Auditor’s office is participating in this joint audit, and, as a result, conducted a special review of the state's home health care expenditures. The findings, comments, and recommendations resulting from this review are presented in the accompanying Management Advisory Report.

MANAGEMENT ADVISORY REPORT

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
AND
DEPARTMENT OF HEALTH

SPECIAL REVIEW OF THE
HOME HEALTH CARE EXPENDITURES
SUMMARY OF FINDINGS

1. Authorizations for Plans of Care (POC) (pages 7-9)

   Individual POCs were not always signed by the physician, were signed by the physician after the certification period started, or were not dated by the physician. In addition, verbal orders from the physician were not always properly documented by the attending nurse or therapist. We noted approximately $66,000 in claims paid when the POC was not properly authorized.

2. Survey Inspection Procedures (pages 9-11)

   The DOH's inspection procedures for ensuring deficiencies are corrected appear inadequate. We noted instances in which deficiencies that supposedly were corrected during a follow up visit were cited again within four to ten months after the follow up was performed. In addition, the survey report did not adequately document the procedures performed to determine that the deficiency was corrected.

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
AND
DEPARTMENT OF HEALTH

SPECIAL REVIEW OF THE
HOME HEALTH CARE PROGRAM

MANAGEMENT ADVISORY REPORT

1. Authorizations for Plans of Care (POC)

The Department of Social Services, Division of Medical Services (DMS) is responsible for ensuring that Medicaid payments to home health agencies (HHAs) are for authorized services provided to Medicaid recipients. The controls over claims processing of home health claims include the following:

- The Missouri Medicaid Information System (MMIS) uses edits to check claim payments to determine if they are for services rendered to eligible recipients by authorized providers and that these claims do not duplicate previous payments to the HHA.

- Home health claims go through an edit that requires review by medical personnel to ensure that a plan of care is on file.

We selected 42 recipients who received frequent home health care services from 5 HHAs. For these 42 recipients we reviewed supporting documentation for nursing, therapy, and home health aide services provided during the period July 1, 1997 through February 28, 1999. This documentation included 324 individual POCs and visit notes which helped support the services claimed.

The Missouri Medicaid Provider Manual requires the POC to indicate the type of services to be provided, be signed and dated by the physician, be reviewed and re-established by the physician at least every 60 days, and the certification period cannot exceed 2 calendar months or 62 days. In addition, there must be a verbal order prior to delivery of the services when services are provided from the beginning of the certification period and before the physician signs the plan of care. The verbal order must be documented, dated, and signed by the nurse or therapist. The physician must sign and date the POC no earlier than ten days before the beginning of the certification period. If the physician omits the date, the home health agency (provider) must enter the date the plan of care was received back from the physician.

During our review of the 324 plans of care for the 42 recipients with claims totaling $250,578, we noted the following problems:

1. Care was provided before the POC was signed and no verbal order was documented for these services. In total, 4 POCs were signed by the physician after the certification period ended. Three POCs were not dated by the attending nurse and 1 POC was dated by the attending nurse after the certification period started.

2. Five of the 324 POCs were signed by the physician more than ten days before the beginning of the certification period.

3. Sixty-three of the POCs were not dated by the physician. Of the 63, 1 was not dated by the HHA. Also, 1 POC was dated by the HHA after the certification period had ended.

4. Seven of the 324 POCs were signed by the attending nurse (indicating a verbal order was given by the physician), however, these POCs were dated two to six months before the certification period started.

5. In 4 instances, changes to treatment on the care plan were not signed by the physician. Instead, an "on file" comment was used in place of the physician's signature.

Documentation of the physicians order for home health services, and appropriate specification of the certification period, is necessary to ensure compliance with the Medicaid Provider Manual and related state and federal regulations, and to ensure necessary and appropriate care is being provided. In total, we noted approximately $66,000 in claims paid when the POC was not properly authorized or dated.

WE RECOMMEND the DMS establish procedures to ensure payments are made for only those home health services supported by a properly authorized care plan. Procedures may include educating home health agencies about the care plan requirements such as physicians signature and date, attending nurses signature and date when a verbal order is given, a certification period for no longer than 62 days, and signature and date on all verbal orders making a change to the original care plan. In addition, the DMS should review the POCs to ensure the required signatures and dates are included before claims are paid.

AUDITEE'S RESPONSE

1. We agree these POCs are out of compliance with Medicaid Home Health Program policy.

We also agree the services provided prior to the date the verbal order was obtained are out of compliance with Medicaid Home Health Program policy. It should be noted, however, that Missouri Medicaid requires the Home Health Agency (HHA) document physician verbal orders in the medical record, not necessarily on the HCFA 485. The Department of Health, Bureau of Home Health and Hospice Licensure and Certification, reviews the medical record for documentation of verbal orders when conducting surveys for licensure and certification. Thus, documentation of verbal order is not reviewed during claims processing.

The auditor did advise there was no other verbal order documentation found in the medical record.

2. *We agree these POCs are out of compliance with Medicaid Home Health Program Policy.*

3. *We disagree with this finding. Medicaid Home Health Program policy allows the date the HHA received the signed plan of care to be used when the physician omits the signature date. Of the 63 plans of care referenced, 56 were in compliance with this policy, 2 were not in compliance (reference below) with this policy, 4 were not available to review, and 1 had no claims in our system with the certification period listed.*

   We agree the POC which was not dated by the HHA was out of compliance with Home Health Program policy.

   We also agree the POC which was dated by the HHA after the certification period ended was out of compliance with Medicaid Home Health Program policy.

4. *We agree these POCs are out of compliance with Medicaid Home Health Program Policy. It should be noted, 5 of the POCs that were reviewed were all from the same HHA. The nurse's signature date is computer generated and is the same date as the "Start Of Care" date shown in field 2 of the HCFA 485. It is apparent this may be a problem with this specific HHA. The HHA will be contacted and given instructions regarding program policy.*

5. *We agree with this finding. These POCs are out of compliance with Medicaid Home Health Program Policy.*

To address the above findings, providers will be educated through a Missouri Medicaid Provider Bulletin regarding Medicaid's requirements for the plan of care, specifically addressing the physician signature and date, documentation of verbal orders, certification period requirements, and interim orders. In addition, Missouri Medicaid's claims processing agent, GTE Data Services, will be provided with copies of the POCs they reviewed which were not in compliance with Medicaid Home Health Program policies to be used in educating their staff.

2. Survey Inspection Procedures

The Department of Health (DOH) is responsible for performing the initial and follow up survey inspections of all home health agencies for certification into the Medicare Program and is responsible for ensuring all home health agencies are properly licensed for operation within the state. After the DOH identifies state and federal deficiencies during its survey inspection, the home health agencies are allowed to respond with a plan of correction for the deficiencies. After the DOH approves the plan of correction, the HHA is re-certified and licensed. Another visit is scheduled with the home health agency to ensure compliance with the plan of correction. During our review of the DOH's survey inspection follow-up procedures, we noted the following concerns:

A. The DOH needs to improve procedures to ensure deficiencies are corrected. We reviewed 30 home health agencies and noted 7 HHAs had a total of 12 deficiencies that supposedly were corrected during the follow-up visit, but were cited again during a subsequent annual survey. Some deficiencies were cited again within four to ten months after the follow up visit. DOH has the authority to terminate a HHA for deficiencies that endanger the lives of the clients. However, according to DOH, it currently does not have the authority to impose fines or other sanctions. Other sanctions could include decertifying an HHA from participation in the Medicaid Program, or prohibiting an HHA from accepting new clients until the deficiency is corrected. The DOH should seek legislation for the authority to impose stronger actions against HHAs that are cited for repeat deficiencies.

B. 1) During the follow up visit to the home health agency, the DOH reviews a significantly smaller number of clinical records. The DOH indicates that a significantly smaller number of records is often reviewed, because Medicare regulations allow the DOH to only review services provided since the survey and only records related to the deficiency cited.

If the majority of the records reviewed in the follow up visit are in compliance with federal and state regulations or established standards, the DOH concludes the deficiency has been corrected. For example, in one survey inspection we reviewed, the DOH found 11 exceptions (for the standard which requires drugs and treatments be administered by the HHA staff only as ordered by the physician) out of 25 records reviewed during an annual survey. During the follow-up survey four months later, the DOH reviewed five clinical records and found one still contained the deficiency. The DOH concluded the deficiency was corrected. In another survey, the DOH found 15 exceptions (for the standard which requires care to follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or pediatric medicine) out of 25 reviewed during an annual survey. During the follow-up survey four months later, the DOH reviewed five clinical records and found two still contained the deficiency. However, the DOH again concluded the deficiency had been corrected.

Based on the results of these surveys and the number of times the HHAs are cited for the same deficiencies in subsequent survey inspections, the DOH should establish procedures to ensure a more representative sample of records are reviewed during the follow-up visit. In addition, the DOH should re-evaluate the criteria used to determine when a HHA is in compliance with the established standards and regulations.

2) We also noted the survey report or other documents did not adequately document procedures performed to support DOH's conclusion that deficiencies were corrected. Although the reports would indicate the number of records reviewed and restate the deficiency, there was no documentation to

indicate which records were reviewed, which had problems noted, or how the conclusion was reached.

Without adequate documentation, there is no assurance that DOH adequately reviewed the records for compliance with state and federal regulations or established standards.

WE RECOMMEND the Department of Health:

A. Seek legislation for the authority to impose stronger actions against HHAs that are cited for repeat deficiencies.

B.1. Establish procedures to ensure a more representative sample of records are reviewed during the follow-up visit. In addition, the DOH should re-evaluate the criteria used to determine when a HHA is in compliance with the established standards and regulations.

2. Establish procedures to adequately document procedures performed to support DOH's survey inspections and conclusions.

AUDITEE'S RESPONSE

A. The recommendation to seek legislation for the authority to impose stronger actions against HHAs that are cited for repeat deficiencies will be referred to Department management for discussion/decision. The recommendation will also be placed on the agenda for discussion with the Home Health Advisory Council at their next meeting.

B. The procedure for conducting state licensure follow-up surveys, and for supporting documentation of conclusions made for follow-up survey activity, will be reviewed and revised to ensure adequate records are reviewed for compliance in the deficient area.

This report is intended for the information of the department's and the division's management and other applicable state government officials. However, this report is a matter of public record and its distribution is not limited.

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